PATIENT QUESTIONNAIRE

Name _____ Date _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Birthdate _____ Age _____ Sex _____ Spouse's Name _____

Are you: _____Married _____ Single _____ Divorced _____ Widowed _____Student

Social Security Number _____/_____/_____ Spouse's Social Security Number _____/_____/_____

Person responsible for payment of this account. (If same as above, please omit.)

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Relationship to Patient _____

Employer _____ Social Security No. _____/_____/_____

Employer _____ Position _____

Address of Employer _____ Phone _____

Spouse's Employer _____ Position _____

Address of Employer _____ Phone _____

Do you have dental insurance? _____ yes _____ no

	PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name		
Insurance Company		
Social Security Number		
Birthdate		
Carrier/Group Number		
Relationship to Patient		

Credit Card Name	MC or VISA	Account Number	Expiration Date

DENTAL HISTORY

How long since you last visited a dentist? _____ Reason? _____

Have you ever had any teeth extracted? _____ Were there complications? _____

How often do you brush your teeth? _____

Do you use dental floss? _____ How often? _____

Do you have a problem with bad breath? _____

Do you have any painful areas, sensitive teeth or bleeding gums in your mouth at this time? _____

Where? _____

What is the reason for your dental visit? _____

What would you like to change about your smile or teeth? _____

Are you interested in	Yes	No
Whiter or brighter looking teeth	( )	( )
Orthodontic treatment to straighten teeth or correct bite	( )	( )
Replace missing teeth	( )	( )
Correct chipped or broken teeth	( )	( )
Replace old unsightly fillings	( )	( )

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MEDICAL HISTORY

	Yes	No
Have you been under a physician's care or hospitalized within the last 2 years?	( )	( )
Please state reason _____		
Have you taken any medication or aspirin in the last 48 hours?	( )	( )
Please list _____		
Are you allergic to any medication?	( )	( )
Please list _____		
Have you ever had any type of reaction to penicillin?	( )	( )
Have you ever had a reaction to a local/dental anesthetic?	( )	( )
Do you bleed easily, or of long duration when cut?	( )	( )
Have you had a blood transfusion within the last two years?	( )	( )
Have you had any heart problems, heart valve damage, congenital heart disease, artificial heart valve, or pace maker?	( )	( )
Please list _____		
Have you had any artificial joint replacement, pins, or plates put in your bones?	( )	( )
Please list _____		

Circle any of the following which you have had:

Anemia	Hepatitis	Low Blood Pressure
Asthma	HIV (AIDS)	Pneumonia
Cancer/Tumors	High Blood Pressure	Rheumatic Fever
Diabetes	Jaundice	Sinus Trouble
Epilepsy/Seizures/Fainting	Liver/Kidney Disease	Stroke
Heart Surgery/Problems		

Have you had any other serious illnesses?	( )	( )
Please list _____		
Have you been exposed to HIV (AIDS) through surgery, transfusion or intravenous drug use, or prior sexual history?	( )	( )
(Woman) are you pregnant now?	( )	( )

Who is your physician? _____ Phone Number _____

Who may we thank for referring you to our office? _____

If you are completing this form for another person, what is your relationship to that person? _____

I accept full responsibility for the above information and understand I am responsible for payment of services rendered.

Signature _____ Date _____